NON-PREJUDICIAL AGREEMENT
(DWC-20)

General Instructions:

- Completed by: Claim Administrator.
- Time Frame: No set time frame for making initial payment. However, once payment is made, a copy of the Non-Prejudicial must be filed with the Department of Labor and Training (DLT) within 10 days.
- Distribution: Original to DLT. Copy to the employee and his or her attorney by certified mail or sent with compensation check.
- Attachments: A wage statement for each employer and a dependency form.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee:
- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.

2. Employer:
- *FEIN:* Employer's Federal Employer Identification Number.
- *Name:* Employer's actual name where the employee was employed at the time of the injury.
- *Address (including city, state, zip):* Address of the employer's actual location.
- *Phone/Ext:* Phone number and extension (if necessary) of the employer's facility.

3. Insurance company named on WC Policy:
- *FEIN:* WC Insurance company's Federal Employer Identification Number.
- *Name:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
- *Phone/Ext:* Phone number and extension (if necessary) of the named WC insurance carrier.
- *RI License Number:* License number issued by the RI Department of Business Regulation (DBR).

4. Claim Administrator*:* If this information is identical to the information in Block 3, check the 'Same' box. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the company administering the claim.
- *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
- *RI License or Self-Insurance Number:* License number issued by DBR or Self-Insurance Certificate number issued by DLT.
- *Injury date:* Date that the accident happened.
- *First date of first disability:* First full day that the employee lost from work during the first period of disability for the injury.
- *Place where injury occurred:* City and State where injury took place.

5. Disability Type:
- Check the appropriate box(es) and enter incapacity date or appropriate start date. Do **not** adjust date for three-day waiting period.
- *Death Benefits/Date of Death – Payable to:* Date of death and name of eligible dependent to whom payment shall be made.

6. Rate Information:
- *Single/Married:* Check one.
- *Number of Exemptions:* Enter figure from *Total Number of Exemptions* box on Dependency form (DWC-04).
- *AWW (include bonus/no OT):* Enter average weekly wage that contains the averaged bonus amount, but not overtime (line 5 under *Calculation of AWW* on the full or part-time wage statements). Note: Adjust amounts throughout for multiple wage statements.
- *Average Overtime Amount:* Enter averaged overtime figure (line 6 under *Calculation of AWW* on the full or part-time wage statements).
- *AWW including Overtime:* Enter total average weekly wage (line 7 under *Calculation of AWW* on the full or part-time wage statements).
- *Spendable Base Wage:* Enter appropriate figure from Gross Wage to Spendable Earnings Table.
- *Base Compensation Rate:* Base compensation rate is 75 percent of the Spendable Base Wage, up to the maximum rate.
- *Number of Dependents:* Enter total number of dependents (not exemptions). Include **non-working** spouse.
- *Weekly Dependency Rate:* **Total Incapacity Only**. $15 per dependent or $40 per dependent for death claim.
- *Total Weekly Rate:* Enter total weekly compensation rate. Note: Compensation rate plus dependency rate cannot exceed 80 percent of the total average weekly wage. Difference should show against the dependency rate on the Agreement.

7. Date of Initial Payment:
- Enter the date of the first payment made under the Non-Prejudicial Agreement.
- *Other Employers/Recurrence* block: Complete and attach appropriate information, if necessary.
- *Signature/Date:* Signature of the person who filled out the form and the date that the form was prepared.
- *Print Name/RI Adjuster License Number/Phone & Extension:* Clearly enter the name of the person who filled out the form, their RI Adjuster License Number as issued by the RI Department of Business Regulation, and the complete phone number of the preparer. Note: DO NOT ENTER SSN – Request another number from DBR.